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FILED MAY 31 1949THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 15548
Registral's No. 462

BIRTH NO.		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 2000		Registral's No. 462			
1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene 29					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. LENGTH OF STAY (If this place) 2 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield 2					
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's 1				d. STREET ADDRESS (If rural, give location) 2040 N. Benton A 6					
3. NAME OF DECEASED (Type or Print) Lula Jane Latham			a. (First)			b. (Middle)			
4. DATE OF DEATH May 24 1949			c. (Last)			4. DATE (Month) (Day) (Year)			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2		8. DATE OF BIRTH Mar. 31 1874		9. AGE (In years last birthday) 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Greene Co. Missouri A			12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME William Stokes			13b. MOTHER'S MAIDEN NAME Matildia O'Dekk			14. NAME OF HUSBAND OR WIFE Widow			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME Orville Latham				ADDRESS Springfield	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerosis, generalized</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH Several yrs. 4500	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 5-9 1949, to 5-24 1949, that I last saw the deceased alive on 5-24, 1949, and that death occurred at 1:15 a.m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Bruce Lemmon J. M.D. Spfld, Mo.				23b. ADDRESS			23c. DATE SIGNED 5-24-49		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-26-49		24c. NAME OF CEMETERY OR CREMATORY Robberson Prairie		24d. LOCATION (City, town, or county) (State) 7mi. N. of Springfield Mo			
DATE REC'D BY LOCAL REG. 5/26/49		REGISTRAR'S SIGNATURE W.S. Handley			25. FUNERAL DIRECTOR'S SIGNATURE W. Klingner Co. Spfld 7m3				

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

..... Student Embalmer No.

working under my personal supervision.

Signed.....
Student Embalmer

Signed

Licensed Embalmer No. 4071

R. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed; fact should be so stated above.